KANSAS MEDICAL JOURNAL.

VOL. VI. TOPEKA, KANSAS, SATURDAY, NOVEMBER 3, 1894. No. 44.

ORIGINAL ARTICLES.

Ophthalmia Neonatorum.

BY J. W. MAY, M.D., KANSAS CITY, KAS.

Read before the Eastern Kansas Medical Society, Kansas City, Kas., October 9, 1894.

Mr. President and Gentlemen: I have selected "Ophthalmia Neonatorum" as my subject, not on account of its rarity, but on the contrary, because of its frequent occurrence and the appalling results that sometimes, and I may say often, follow in its wake. When we consider that one-third of the blindness of Europe is due to this cause (and I dare say statistics would show nearly as bad a state of affairs in our own country), it should make this the most interesting subject we could discuss.

I take it, Mr. President, that we are too prone to hunt for rare cases and pay too little attention to the more important diseases that afflict mankind so frequently and so seriously, and which is of so much interest to the general practitioner.

We will now briefly proceed to the ætiology, diagnosis, prognosis, treatment, and last, but of most importance, prophylaxis. As to ætiology (quoting from a leading oculist), "It is generally due to contagion or from an acute or chronic discharge from the female organs that may or may not be gonorrheal." I am aware that it is an unsettled question as to whether or not all cases of ophthalmia of the new-born are due to the gonococcus, or in other words, due to gonorrhea. Be that as it may, I do not deem it of any practical importance as long as we keep in view the fact of its contagiousness. My own view of the matter is that the majority of the cases are caused by the specific gonorrheal poison, and yet I believe that there are acrid discharges from the maternal parts which will produce, to all outward appearances, the same disease and which yields to the same course of treatment. We will leave this phase of the subject still in an unsettled state.

As to diagnosis, that is familiar to you all. The swelling of the lids, photophobia, redness of the conjunctiva, chemosis with serous discharge which appears about the third day, the discharge soon becoming creamy or of a greenish hue, and the lids so stiff that it is frequently impossible to evert them, all go to mark the attack as one of ophthalmia neonatorum.

As to prognosis, it is generally favorable if seen early, and proper treatment carried out. The greatest danger is to be expected from corneal ulcers and consequent perforation. My experience is that it affects both eyes nearly simultaneously; at any rate, I have never seen it affect only one eye, and this is explained by the fact that it would almost be impossible to pass the maternal parts without inoculating both eyes at the same time.

The treatment at first, if seen before the purulent discharge begins, should consist of cleanliness mainly, and this is accomplished by means of hot boracic acid solution, two or three grains to the ounce of boiled water, and the eyes should be cleansed every hour, using great care not to use any undue force as the eyes are very tender and easily made worse by rough handling. I have used the bichloride solution also, but as I have gotten just as good results with the boracic acid I usually prefer it on account of its non-toxic qualities.

As soon as the discharge becomes purulent we must begin the use of nitrate of sil-

ver. I have found five to ten grains to the ounce to be sufficiently strong, and it should be used daily in most cases. In this connection I wish to give you my method of making applications. I never use brushes or probes with cotton on, but always have at hand a supply of wooden toothpicks and use them instead of the probe by rolling a little cotton on the pick. The advantages are, you use them only once, whereas by using the probe or applicator, you run the risk of infecting some one by using the same applicator. This may be old to most of you, yet I consider it a safe and very neat way of making applications, especially where there is danger of contagion. It is most important that this discharge be removed frequently as it is very dangerous to the cornea. Every hour the eye should be cleansed and the cornea examined as to its condition. The treatment, of course, must be varied from time to time, but that is familiar to you all.

Now, will take up the closing division of my paper, which I regard as very important, and hope that it will be very generally discussed. Since Crede introduced or promulgated the idea of preventing ophthalmia of the new-born by disinfecting the maternal passages and applying only once a two per cent. solution of nitrate of silver to the conjunctival sac, it has had a remarkable effect in reducing the number of cases. This plan is proper, perhaps, in large lying-in hospitals, but in private practice I do not believe it is necessary unless there is some evidence or reason to suspect gonorrhea in the mother.

The indiscriminate use of nitrate of silver solutions as strong as recommended by Crede might do harm, yet I would not hesitate to use it if I deemed it necessary. An eminent Philadelphia oculist has said that any obstetrician who failed to put a silver solution or other disinfectant in the eyes of a new-born babe should be deprived of his diploma. I am afraid a great many would be without diplomas if this order should be enforced.

I believe that hot boracic acid solution, two or three grains to the ounce, is sufficient for cleansing the face and eyes immediately after birth, and then be careful to use nothing unclean about the infant, as you may carry the infection in dirty sponges, towels, or cloths. In most cases perfect cleanliness will suffice, and yet it is to be remembered that it is difficult to discriminate in which cases to use the heroic measures.

As you will see I have not read an exhaustive paper on the subject, but wish to bring out some discussion on the important subject of prophylaxis.

I will be pleased to have this phase of the subject fully discussed, and ask the gentlemen to give their methods as to prophylaxis.

Hydrophobia.

BY J. A. RAFTER, M.D., HOLTON, KAS.

Editor Journal.

The following case recently occurred in my practice:

On the evening of October 19 I was called to see Frank R., a strong, well-developed boy of 15 years of age. During the day he had complained of a vague, uneasy feeling, saying while he was not particularly sick, he felt badly, and was apprehensive concerning his condition. As he had been engaged in a football game the day before, his mother gave little heed to his complaints, supposing he had over-exerted himself, and would feel better after a night's rest.

As the day advanced, however, he became more restless, and urgently requested that I be sent for. As I entered the room Frank was seated at a table making a hesitating and ineffectual effort to get a cup of coffee to his lips. When he saw me he dashed the cup to the floor and came rushing wildly toward me saying some one was attempting to make him drink when he could not. Scarcely were the words uttered when he fell to the floor in a convulsion. This was the first one and of short duration. At once when consciousness returned he asked for water. I attempted to give him a drink

but as soon as he saw the water he dashed away wildly, and very soon had another convulsion.

I was suspicious, and asked the mother if he had been bitten by a dog. She had no knowledge of such an occurrence. His brother, however, informed me that not long since, while in Leavenworth, Frank had been bitten on the foot by a dog, who afterward bit a colored boy and attempted to bite a man who killed the dog. The wound on Frank's foot was not a severe one; it healed kindly in a few days, and no more was thought about it.

This information, with the symptoms the boy presented, convinced me that I had a case of hydrophobia to deal with. During the second convulsion I gave a hypodermic injection of morphia sulphate ¼ grain, with atropia sulphate 1-150 grain. This was followed fifteen or twenty minutes later with two tablets of strychnine, each 1-50 grain. Under the influence of the injected drug the boy became more quiet for a time, giving me an opportunity to supply myself with chloroform.

For perhaps two hours the patient was comparatively quiet, complaining only of a pain in his leg (the one bitten), and of a sense of constriction in the throat, with difficulty in swallowing, and also of a profuse and persistent salivary secretion which kept him constantly hawking and spitting.

During the early part of the night all symptoms detailed above gradually became more intense. Hypodermics seemed to have no effect. I then brought him well under the influence of the anesthetic and with it was able to control to some extent the convulsive paroxysms. But with the chloroform, and in spite of it, often and with increasing force returned those horribly violent spasms of the throat and neck. Stimulation by the bowel, and hypodermically, was resorted to, but exhaustion increased, and the boy died twelve hours after I first saw him.

In the beginning the pulse rate was not much increased, nor the temperature elevated, but as the disease advanced the pulse became frequent and feeble, and the temperature became elevated. His reason at first was clear when he was free from convulsions, but later on his mental faculties became impaired. Wild and maniacal excitement came on with hallucinations of sight and hearing.

I report this case with the firm conviction that no error was made in the diagnosis. It was a desperate case and its termination unfortunate.

Not all cases that are inoculated with the virus of rabies have hydrophobia. I believe at this time there is not a single recorded recovery from genuine hydrophobia.

Suicide.

Medical Record.

The number of suicides has increased so much in England in recent years, that the question has been raised whether the elimination from insurance policies of the clause dealing with that subject has not tended to encourage self-destruction. One of the leading insurance journals has taken the matter up, and concludes that the cause must be sought elsewhere; and that it is only very rarely that a man puts an end to his life from a desire to benefit his family, although it is possible that, having already made up his mind to kill himself, he may take out extra insurance for the sake of his wife and children. Such deliberate suicide is, however, among the most seldom of occurrences. Some German statistics recently published, shows that Saxony heads all the other States of the Empire in the matter of suicides, the percentage being almost double that of Prussia. One per cent. of the suicides are children under 12 years of age.

It should uot be forgotten that gonorrhea is liable to produce heart trouble. It may be pericarditis or endocarditis. Palpitation, pericardial, friction sound and acceleration of the pulse are all liable to occur in chronic gonorrhea.

Kansas Medical Journal.

PUBLISHED WEEKLY.

SUBSCRIPTION PRICE, INCLUDING POSTAGE:

Per annum, in advance..... $1 00
Single copies..... 15 cents

Subscription may begin at any time. The safest mode of remittance is by bank check or postal money order drawn to the order of the undersigned. When neither is accessible, remittances may be made at the risk of the publishers, by forwarding in Registered Letter. Address

KANSAS MEDICAL JOURNAL,
723 Kansas Avenue.

W. E. McVEY, B.S., M.D., Managing Editor.

Collaborators:
J. E. MINNEY, A.M., M.D., Topeka, Kas.
S. G. STEWART, M.D., Topeka, Kas.
J. C. McCLINTOCK, A.M., M.D., Topeka, Kas.
M. B. WARD, A.M., M.D., Topeka, Kas.

Topeka, Kansas, Saturday, Nov. 3, 1894.

Is Medical Co-Education a Failure?

This question is asked in an editorial in the *Medical Review*, St. Louis. In summing up the answer the editorial says: "Not knowing the particulars we cannot decide, as already stated, whether so large a percentage of lady students is a sign of failure of medical co-education; still, we most emphatically believe that, as a rule, the co-education of the sexes in certain branches of medicine is impractical and should be discouraged, no matter whether the cause of the failure of co-education is to be attributed to the male or female sex."

Dr. William Osler is credited with this statement: "I was warmly in favor of it, particularly when the ladies came forward and offered half a million dollars. I come here to-day with tears in my eyes and sorrow in my heart, to tell you that co-education has proved an absolute failure from one standpoint. When I tell you that 33.3 per cent. of the ladies, students, admitted to the Johns Hopkins Hospital at the end of one short session are to be married, then I tell you that co-education is a failure. If 33.3 per cent. fall victims at the end of one session, what will happen at the end of the fourth!"

Dr. Osler and the editor of the *Review* are bright men in medicine, but their conclusions and judgment in the medical co-education of the sexes is contrary to our experience and contrary to the new order of society, and contrary to progress.

If getting married is failure, it would be a pleasure to have the whole world fail that way. How much better mother a woman would make who had a medical education or even a knowledge of the primary branches. The doctor should dry his tears; they are pathological, ephemeral. A medical education broadens men and women and makes them better mothers, fathers and citizens. A medical education is not lost because the person does not pursue it as a life work. It is worth all it costs. But the failure in the mind of Dr. Osler is that they get married.

The *Woman's Medical Journal* says:

"Surely this is a little difficult. We were told that the great objection to women entering professional life was that they would not care to marry, hence the desire to keep them out. Now conditions are reversed and the objection is that they do. Really it is not easy to please. A recent address at a meeting gave the advice that all young physicians should marry; that they would secure confidence and entree to homes otherwise inaccessible. If marriage is good for one it must be good for another.

"Our experience is that the majority of women in the profession are married and being married, still maintain their profession. Marriage is not the end of life, is but a condition which admits of the usual daily rounds of duty. When a young man marries he does not close up his business, why should a woman? Because a woman marries is no reason for concluding she is a failure. It is

not just, neither is it fair. Women are human the same as men, this setting them on a pedestal and crowning them with a lot of cast off virtues, beautiful but impractical, is not in vogue to-day. The women have paid their way well at Johns Hopkins and it strikes this journal that if co-education is a failure, the cause is not in the women."

In conclusion we most emphatically believe after a personal experience of five years that medical co-education in all branches of medicine is practical, desirable and a decided success.

The Kansas Medical College.

The trustees and faculty did the right thing in securing a home for the school. The class is the largest in the history of the school. Some sixty students have matriculated, but there are fifty-five *bona fide* matriculates.

The growth of the school is not remarkable nor phenomenal, but creditable and encouraging. It is not nor never has been a boom school. Its growth has been gradual and healthy. The authorities have been cautious and conservative, and hence not a step backward has been taken, but forward has been the watchword. In securing the ten lots and the large brick building for the new home, the management is under obligations to many of the citizens and business men of Topeka for substantial assistance, and their names will be mentioned when the completed list is made up.

There is room in the building for a class of one hundred students, and from present indications more room will be needed in the near future.

The College has ten beautiful lots on which the building stands, in the most eligible, healthful and beautiful part of the city. It is more ground than the school will ever need for strictly school purposes, and the trustees have proposed to donate of these lots to the amount of $5,000 to the Presbyterian Church if the church will erect a hospital on them. The proposition was made to the Presbytery and accepted. The Presbytery sent delegates to the Synod and the proposition was accepted by the Synod of Kansas, and a committee appointed to meet in Topeka with a similar committee from the College to complete the arrangements.

The school has pushed the authorities and not the authorities the school from the beginning. First rooms were secured on Jackson street which soon proved inadequate. Larger quarters were secured in the Dennis block which were soon filled to overflowing, and the last and best effort culminated in purchasing a permanent home.

A number of lectures will be given on Saturday evenings at the College to the students by physicians throughout the State, to which all physicians are invited. Dr. W. B. Dewees, of Salina, addressed the students and faculty on Saturday evening, October 20, on "Painless Childbirth." The lecture was highly creditable and was appreciated.

It will afford the faculty great pleasure to have the physicians in the city and visiting physicians visit the school.

Public Schools.

The State Board of Health is after the public schools in Kansas City, Kas. The school board claims to have entire control of the sanitation of the schools, which is a mistake. It seems strange that school authorities should not only be willing but ask the sanitary authorities to assist them in inspecting the school-rooms and surroundings. Our schools are the foci for the congregating and the disseminating of all kinds of infectious diseases.

The large number of children congregated necessitates constant attention and care in keeping the rooms free from crowd poison and all effete matter sewered. We are told that the death rate of school children in Boston is greater than that of either London or Berlin—ranging in children from 5 to 15 years of age, the rate is 6.6 in Boston, as compared to 4.8 in Berlin and 3.9 in Lon-

don. The director of physical training in the Boston schools, Mr. Hartwell, claims that this result is due to the lack of proper sanitation in the school rooms. It is not only so in Boston, but there is danger in every school. In the country districts the school-room can be easily ventilated, if not properly done, but the outhouses are a constant menace to the children. The State Board of Health, every sanitary officer and physician should feel it a self-imposed duty to instruct the people in this matter and assist in enforcing obedience to the laws of health.

Another Craze.

The anti-toxine serum craze is on. Dr. George E. Shrady, editor of the New York *Medical Record*, and Dr. Louis Fischer, of New York city, have received a small quantity of the serum for the cure of diphtheria from the laboratory of Prof. Behring, of Berlin, its discoverer. It is claimed that the new treatment is a success. The horse is said to be the best adapted for transferring the diphtheritic poison into an antitoxine.

In one of the French hospitals the death-rate from diphtheria has been reduced from 51.70 per cent. to 24.33 per cent. It is also said to be a prophylactic to a certain extent. It is used hypodermically, and two injections at most is sufficient to cure.

By calling this new treatment for diphtheria "a craze," we do not wish to be understood as deprecating experiment or raising our voice against trying anything and everything that promises success or looks reasonable. But we do hope that the profession in general will not be hasty in adopting this treatment until Dr. Shrady and others report their experience and confirm or refute the reports of our German and French confreres. The Bergen, Brown-Sequard and Koch waves came and dashed against the breakers and have sunk back to their proper place. The two last mentioned may have done some good, especially the latter, but more lives probably have been destroyed by either then saved.

It is trying on the profession to be questioned and twitted by the laity, who have seen these glowing newspaper accounts of wonderful cures, as to whether they have tried the remedy, and then to see the look of "why, doctor, I thought you were up to the times, for I know all about that." And then if the doctor has tried it and the results were unfortunate, they are ready to censure him as a dangerous experimenter. New things must be tried and experiments made in order to find out, to progress, but haste must be made slowly, and it is better for scientific medicine that a few persons die from natural causes than for a large number to be killed from lack of knowledge or overzeal in the use of new and dangerous agents in the interest of progressive medicine.

Reform in Funerals.

A memorial has been presented to the Home Secretary by a deputation from the Church Funeral Reform Association of England, "asking for an inquiry into the evils attendant upon prevailing modes of burial with a view to improve legislation, as also an inquiry into the effect of earth to earth burial.

"An effort is being made by the society to induce persons of means and influence to promote a simple, economical and scientific mode of burial, in accordance with sanitary law, which shall dispense with durable coffins and vaults. Attempts have been made to inculcate the idea of friends subscribing to a hospital or spending their money in helping the living in token of their respect for the dead, rather than by large expenditure upon excessive floral decorations."

THE Extract of Buchu man, Dr. H. T. Helmbold, died in the insane asylum at Trenton, N. J., last week. He was 57 years old and had been in the asylum three years.

Mississippi Valley Medical Association.

The Association meets in Hot Springs, Ark., November 20, and continues in session four days. This meeting bids fair to equal the American Medical Association in numbers and interest. The Iron Mountain Railroad offers one fare for the round-trip. This is an excellent opportunity for the physicians of Kansas to attend one of the best medical societies in the United States and at the same time gain a knowledge of Hot Springs, which will enable them to advise their patients of the virtues of the springs and the surroundings and conveniences intelligently. We hope to see a good representation from Kansas.

Phthisis.

"Dr. Loomis, of New York, in the American Climatological Association, in speaking of the treatment of phthisis, thought that drugs exerted but little if any influence on this disease aside from improving the digestive powers in certain patients."

We believe from our own experience and from the experience of a host of intelligent practitioners, that drugs are efficacious. Beechwood creosote is one of the best agents.

Eruptions from Iodine.

St. Louis Medical and Surgical Journal.

The following appears in a recent issue of the *Medical and Surgical Reporter:*

Dr. Szadek (*Gazzetta Degli Ospeddali*, No. 82, 1894) distinguishes five forms of iodic eruptions: the erythematous, the papulo-pustular, the bullous the tuberous, and the hemorrhagic.

The erythematous form is characterized by extensive disseminated areas in various regions of the body, particularly on the forearm. If the iodine be continued it may be transformed into the papular variety, which, with the pustular eruptions, is usually observed on the face and scalp; it greatly resembles that following the bromides, except that the confluent form is very rare.

The bullous variety is observed as large disseminated bullæ upon the head, face, neck, extremities, and trunk. If the drug be continued, and especially in large doses, the bullæ take on a purple-reddish color and become filled with sero-pus mixed with blood.

The tuberous form is not different from urticaria and erythema nodosum, but is more striking and less circumscribed in large and elevated nodes. It is localized chiefly on the head and lower extremities. This form sometimes passes over into the ulcerating variety.

The hemorrhagic form, as a rule, is not severe, and is situated upon the legs. Generally it develops at the beginning of the treatment, and it may follow small doses.

The writer has observed two peculiar cases of iodic exanthem. In one the eruption consisted of large and disseminated elevations and bullæ upon the extremities. In the other, hemorrhagic exanthem was produced by small doses of the iodide, and was upon the trunk and extremities. The variability of the iodic eruptions renders their diagnosis difficult. All the lesions usually disappear in a few days after discontinuance of the drug.

Sudden Death on the Bicycle.

"Dr. Petit reports three cases of sudden death following the use of the bicycle." The moderate use of the bicycle is healthful, and with proper precautions with experienced cyclists is no more dangerous than walking.

APHONIA is sometimes caused by inhaling the perfume of flowers.

The Operative Treatment of Perforative Ulcers of the Stomach and Intestines.

Pearce Gould, F.R.C.S., London (Med. Week., 1894; II; No. 32; p. 378).

The pathology of perforating ulcer of the stomach and duodenum is still obscure. It is frequent in young anæmic women of the servant class, and also in middleaged men. Usually it is single and situated on the lesser, rarely on the greater, curvature of the stomach. The size is that of a dime or a quarter; of variable depth, the floor consisting either of perineum or possibly of a thickened area up to the size of a palm.

The symptoms, such as pain, tenderness, hæmatemesis, and malæna, are sometimes slight, or even altogether absent. On the other hand, the pain may be agonizing, with frequent vomiting and voiding of blood. At times the patient makes no complaint whatever; in short the symptoms are no sure guide to the seat or extent of the perforation. In twenty-five per cent. of all cases of gastric ulcer, perforation takes place posteriorly in two per cent. only, while in eighty-five per cent. the perforation is anterior, opening into the abdominal cavity. Young servant girls are especially prone to anterior perforation.

As a prophylactic measure, Billroth recommended timely laparotomy, excision of the ulcer, and suture of the wound. There is nothing to recommend this procedure. The mortality is great and the operation is imperfect from the absence of one essential link, namely, that there is absolutely no sign to localize the exact position of the ulcer, whether front or back, whether cardiac or pyloric. In a large proportion of cases, moreover, the symptoms are so slight as not to warrant a diagnosis. Perforation again is often acute in character. The selection of cases is the keystone of true surgery, but the time will come when we shall be able to diagnose the seat of the ulcer. At present surgeons reach perforations in the posterior wall through an anterior incision; but this I believe to be anatomically indefensible.

Clinically eighty-five per cent. of cases of gastric ulcer recover under the care of the physician, but perforation into the general peritoneal cavity nearly always proves fatal. Death is occasionally due to shock, though more frequently occurring from peritonitis. The acute symptoms usually last twenty-four hours, but occasionally a fatal result occurs immediately. Primary shock varies greatly in its severity, and must be carefully distinguished from collapse. For its treatment surgical measures are of small avail, and little can be done beyond the administration of morphine hypodermatically and warmth. The surgeon's duty consists in the prevention or arrest of peritonitis. The only hope of doing good lies in cleansing the peritoneum. The following measures should be adopted:

1. Simple washing out of the abdominal cavity.
2. Suture of the ulcer.
3. Where the latter is impossible, suturing of the stomach to the abdominal parietes.

It cannot be too often repeated that the success of the treatment depends on cleansing the peritoneum. A case to the point is that of a girl 23 years of age, who suffered from chronic constipation, and who showed no signs of gastric ulcer. She partook heartily of Damson plums, which she swallowed, stones and all. Next day she took a dose of Epsom salts. This was followed by abdominal distension and pain, which commenced in the lumbar region. Twenty-six hours after the onset of the acute symptoms, the belly was opened below the umbilicus. A quantity of gas and acid fluid escaped. Gould cut down on the stomach and excised the ulcer. At the close of the operation, the patient collapsed. She revived, however, after the intravenous injection of a saline fluid, but death occurred nine hours later. On post mortem examination, the sutures were found to be firm, but there was general peritonitis.

The time of performing the operation is a matter of great importance. It should not be done during the first stage of shock. Perhaps too much stress has been laid upon

operating early, and too little on operating well. Practically, however, experience alone can decide the precise period when the operation should be performed. If too long a time is allowed to elapse, peritonitis becomes general and intensified. Moreover, under these circumstances masses of lymph conceal the affected parts and interfere with the effectual cleansing of the sac.

The best site for the incision is in the middle line; this gives the best access to the whole of the abdomen, while the seat of pain is no guide to localization. First among the fluids used for flushing is normal salt solution, and then boiled water; avoid acid or toxic solutions, and use the water hot, as it is a powerful restorative. A vital point is systematic flushing with a large exit tube. Where practicable, sew up the ulcer. The stomach may or may not be washed out; the value of exploration by the finger is doubtful. When in doubt, drainage should be resorted to. If the collapse be not relieved by hot water, practice intravenous injection.

With regard to perforation in typhoid ulcers, excluding doubtful cases, seventeen cases of operation, with one recovery, have been collated. The steps of the operation are the same as for gastric ulcer. Statistics show that there are from 2½ to 3 per cent. of perforations in all cases of typhoid, most frequently occurring in the ileum, often multiple, sometimes so small as to allow no escape of intestinal contents. They usually take place during the third week, but cases are known as late as the sixty-sixth day. The symptoms may be very marked or quite latent. Death may close the scene in ten minutes, but the patient rarely survives more than two days. Recoveries are very rare.

In the discussion of this paper at the meeting of the British Medical Association, Dr. Maclaren emphasized the importance of careful cleansing of the peritoneum. The conditions of success are system, perseverance, and a patient not on the verge of death from collapse. Rectal feeding is all important.

Mr. Rutherford Morison believed that the collapse was often relieved by the anesthetic and the operation. The only condition of collapse which contra-indicates operation is blueness of the face.

Mr. G. Barling considered that the less done in typhoid perforation the better, an opinion in which Mr. Damer Harrison coincided.

Dr. Ward Cousins preferred sponging to douching, and Mr. Haslam advised that the sutures be inserted in sound tissue outside the area of inflammatory thickening.

Dr. Kendal Franks did not approve of operating during the initial stage of shock, but the time to operate is between that time and the second shock or collapse. The ulcer should be excised in all cases, the sutures placed in healthy tissue and the continuous Lembert suture should be employed.

Mr. O'Callaghan was satisfied that the only hope was in early operation and he paid little attention to shock.

Cystitis Colli Gonorrhoica.

Dr. L. Casper, in The International Journal of Surgery.

Under the name of acute posterior urethritis, or cystitis colli gonorrhoica, the author describes a sequel of acute urethritis, which although not infrequent, is but little known. Anatomically, the affection is characterized by the fact that the inflammatory process not only involves the anterior urethra as far as the bulbous portion, but also extends in acute form beyond the bulb into the posterior urethra, that is, into the membranous and prostatic portions as far as the neck of the bladder. Inasmuch as the compressor muscle of the membranous portion of the urethra by its contraction shuts off the anterior from the posterior urethra, the examination of the urine will afford different results in these two affections. In acute anterior urethritis a specimen of urine collected in a test tube at the commencement of urination is turbid, because it contains the secretion of the anterior urethra, while a second specimen collected at the end of urination will be perfectly clear. On the other hand,

in acute posterior urethritis both specimens will appear turbid, because the secretion of the posterior urethra, which has entered the bladder, has become mixed with the urine and rendered the entire amount turbid. Furthermore, in cystitis colli gonorrhoica the urine in the first tube is more turbid than that in the second, while in cystitis of the body of the bladder the opposite is true.

The second sign which points to the localization of the process in the posterior urethra is the passage, usually at the end of urination, of blood or bloody urine—a condition which may be attributed to the fact that in consequence of the stronger contractions of the sphincter vesicæ at the end of urination, the hyperæmic areas around the neck of the bladder are lacerated and bleeding fissures result.

The symptoms of cystitis colli are characterized by the passage of turbid and bloody urine, frequent desire to urinate (every quarter of an hour), or frequent spasmodic pains. The affection occurs in three forms:

1. Cystitis colli gonorrhoica acuta with hemorrhage.

2. Cystitis col. gon. acuta without hemorrhage.

3. The socalled subacute variety.

The treatment consists in the use of hot baths, the administration of laxatives and an abundant milk diet, but especially in urethral irrigation with a 1 to 1000 solution of nitrate of silver. The latter procedure is carried out in the following manner:

After the anterior urethra has been anesthetized with a 3 per cent. solution of cocaine, a French silk catheter which has been lubricated with glycerine is introduced into the urethra. Gradually overcoming the contraction of the compressor urethra muscle the instrument is pushed far enough behind the bulb that the eye of the catheter is situated in the membranous portion. If by means of an ordinary syringe a lukewarm solution of nitrate of silver is now forced through the catheter, it will irrigate the posterior urethra, flow through the sphincter into the bladder, and is evacuated at the next urination. The similarly affected anterior urethra is treated by injecting a second quantity of the silver solution while the catheter is being gradually withdrawn from the canal. If it is difficult to introduce the instrument as far as the right place, it may be allowed to enter the bladder and the injection be made during its gradual withdrawal.

These injections should be repeated every second or third day, the solution varying in strength from 1 to 2000 to 1 to 500. Under this treatment the symptoms rapidly subsided in acute cases, more slowly in subacute and chronic cases, a perfect cure being effected.

In conclusion the author remarks that while irrigation of the bladder with solution of nitrate of silver is indicated in acute posterior urethritis, it is useless in cystitis corporis vesicæ because the silver solution is decomposed and rendered ineffective by the sodium chloride present in the bladder. Injections with ordinary gonorrhea syringes are also irrational, because they do not reach the posterior urethra.

On the Production of Intestinal Asepsis by an Exclusive Milk Diet.

New York Therapeutic Review.

Drs. Gilbert and Dominici described their experiments before the Paris Biological Society; these were carried on upon dogs and rabbits, and in a man and a woman. In man the experiments consisted in the bacteriological examination of the feces, while in animals the intestinal contents were also removed directly from the intestines. In the case of the woman the milk given was sterilized but not so with the man. Notwithstanding this difference the results obtained in both were entirely similar.

It was found that from the first day of the administration of an exclusive milk diet the number of microbes in the feces diminishes, and after this diet has been continued for five days, the amount of microbes becomes sixty-five times smaller than with the ordinary diet.

In animals the different portions of the

alimentary tract were all studied. The diminution of bacteria is notable in the stomach, and is continued in all the other parts. In rabbits this is so marked that the intestinal tract, after some time, becomes well-nigh entirely aseptic.

The causes of this are ascribed by the authors to the fact that milk is rapidly and nearly completely absorbed, that it washes out the alimentary tract, and that the small amount of residuum left allows but a small amount of culture-media for bacteria to remain in the bowels.

It is also probable that the large amount of hydrochloric acid formed after the ingestion of milk has also something to do with this production of asepsis. Dr. Richet, during the discussion that followed, was disposed, however, to give more credit to the action of the lactic acid, whose action on the coil bacillus is well known.

The authors explain the good effects of milk diet in hepatic and renal troubles. When the liver is altered, congested, etc., it becomes unable to destroy or neutralize the toxines brought to it from the intestines. The milk-diet causes such a diminution in the amounts of toxines produced, that the liver becomes relieved of much of its work, and thus has a better chance of returning to a normal condition. In nephritis the milk acts as a diuretic, as we all know, but it does so chiefly because it lessens the amount of toxic material it is compelled to eliminate, by stopping one of the sources of toxic production.

The Starting Point of Tuberculosis in Children.

North American Practitioner.

At a meeting of the London Medical Society, May 7, 1894, Dr. J. Walter Carr presented a paper, reported in the *Medical Weeks*, embracing the results of 120 autopsies on the bodies of children suffering from tubercular disease, from which he deemed the following conclusions warrantable:

1. That tubercular disease usually commences in the glands, the liability being at its maximum during infancy and early childhood. Out of my 120 cases the disease had almost certainly commenced in the glands in 70, or 58 per cent. (including 13 in which glands only were involved), and in 17 more, or 14.2 per cent., there was considerable probability at least that the glands were the primary foci. Excluding the doubtful cases, the glands formed the primary focus in 64.5 per cent. of children under five years of age, and in only 37 per cent. of those above that age.

2. that tubercular lesions in the cervic glands, as in the joints, may arise by infection through the blood stream, but that caseation of the bronchial and mesenteric glands, when primary, is usually, if not always, due to direct infection from the organ with which they are connected, it having been shown that bacilli may pass through the lungs, or the intestinal walls, without producing any recognizable lesion, and that they then enter the lymphatic channels and not the blood vessels.

3. That tubercular disease starts much more frequently in the thorax than in the abdomen, and certainly far more often in the thoracic than in the mesenteric gland. Of the 120 cases, in 79 the disease probably started in the thorax (in 54 certainly and in 12 possibly, in the bronchial glands); in 20 in the abdomen (in 12 certainly and in 2 possibly in the mesenteric glands); and in 6 in one or the other cavity. In only 2 cases were the cervical glands the probable primary focus. The conclusion is that though infection undoubtedly does occur through the intestines, and especially, as experiments on animals have shown, through milk, yet infection through air is far more frequent and important. The disease is so commonly generalized in children that figures, merely giving the frequency with which different parts are affected, are of little value, the important point being to ascertain where the disease is most advanced, that is to say, where it probably commenced.

4. That caseation of internal glands, from the frequency with which it is found after

death, must often exist alone and entirely unsuspected, being doubtless in many cases quite impossible of diagnosis; and that it is very necessary to recognize its frequency and importance, when dealing with obscure febrile conditions in children.

5. That, in regard to treatment, prophylaxis is by far the most important, and that it is probably impossible to prevent bacilli from gaining access; we must try to increase the resisting powers of the system to their entry, above all by keeping the mucous membranes healthy, by dealing promptly with and, if possible, preventing, rickets, the great cause of catarrh in early childhood, and by taking special care of children during convalescence from acute specific fevers, which so depress the vitality of the body generally and the resistant power of its mucous membranes, as well as the filtering power of the glands in particular.

I WILL unhesitatingly say that I consider Peacock's Bromides much superior to the ordinary bromides, and the Chionia I believe to be an extremely successful preparation or a very valuable therapeutic agent. I have used both with excellent success.

JOHN J. SHAW, M.D.,
Plymouth, Mass.

Diseases of the Heart Muscle in Typhoid Fever, Scarlet Fever and Diphtheria.

Medical Fortnightly.

Bomberg (*Deutsche Archiv fur Klinische Medicin*, vol. xlix, parts 4 and 5). In typhoid fever the highest grades of parenchymatous degeneration of the heart-muscle are present by the end of the second week. In scarlet fever insterstitial myocarditis begins mostly at the end of the second week. In diphtheria this degeneration begins somewhat later, at the seventh or ninth day, and is at its highest development at the end of the second or beginning of the third week. The characteristic fatty degeneration of diphtheria begins often very late. Symptoms during the fever: irregularity and smallness of the pulse and dilation. The best sign of dilatation is the gallop rythm. A very slow pulse is a bad prognostic sign of diphtheria. Dilatation is an important physical sign. The amount of urine is usually diminished; there is slight albuminuria with or without hyaline casts.

Physician's Capital.

Medical and Surgical Reporter.

The physician's chief capital is the confidence of his patrons and that of the fellows of his profession. The one who by libelous or slanderous speech impairs or deprives him of this confidence is as much a wrong-doer as if he had deprived him of some specific article of property. The nature of these injuries excludes remedy by restitution. That cannot reach and correct the mischief done.

Fats and Oils.

If the digestive organs of your patients are unable to digest and assimilate fats and oils, then he needs Seng, two or more teaspoonsful before each meal. No person will have consumption whose digestive apparatus is able to digest fats and oils.

THE dorsal decubitus favors suppuration of the middle ear in the exanthematous diseases. The secretions are retained more in that position. Hence it is better to have the patient sit up a portion of the time, especially during the day. If they are too sick to sit up on a chair they should be propped up in bed a part of the time. The upright position favors the escape of the secretion from the nose and eustachian tubes.